September 5, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1652-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This ___ reviewer has been certified for at least level I of the TWCC ADL requirements. This physician is board certified in neurosurgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 44 year-old female who sustained a work related injury on ___. The patient reported that while at work she stepped onto a canister that threw her to the floor. The patient reported experiencing immediate back pain and gradually developed left lower extremity radicular pain. The patient was evaluated in the emergency room on 12/22/01 due to severe lower back pain. The patient underwent X-Rays of the lumbar spine that showed disc space narrowing at the L4-L5 and L5-S1 level with facet hypertrophy at both levels. The patient also underwent an MRI on 1/3/02 that showed decreased signal intensity at the L4-L5 level. The treatment for this patient has included oral pain medications and relaxants and steroid injections times 2. The patient has also undergone a discogram with CT scan following on 1/19/03.

Requested Services

Surgical bone graft iliac crest & insert EBI bond stimulator, surgical lumbar laminectomy & discectomy L5-S1, and surgical posterior lateral fusion L4-L5, L5-S1.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 44 year-old female who sustained a work related injury to her back on ___. The ___ physician reviewer also noted that the patient has been treated with oral pain medications and relaxants and steroid injections. The ___ physician reviewer indicated that the patient has been referred for back surgery.

The ___ physician reviewer indicated that the documentation provided does not demonstrate clear rationale for proposed surgery. The ___ physician reviewer explained that posterolateral fusion for discogenic pain has not been proven to be successful. The ___ physician reviewer also explained that implanted stimulator is not indicated in this patient's condition. The ___ physician reviewer further explained that there is no evidence of a non-union in this patient's condition. Therefore, the ___ physician consultant concluded that the requested Surgical bone graft iliac crest & insert EBI bond stimulator, surgical lumbar laminectomy & discectomy L5-S1, and surgical posterior lateral fusion L4-L5, L5-S1 is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,